STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235733	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Troy	2685 West Maple Road Troy, MI 48084

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2605657. Based on interview and record reviews the facility failed to ensure an appropriate admission, staff competency and ensure coordinated care was implemented prior to the admission of one (R708) of four residents reviewed for quality of care. Findings include:A review of a complaint submitted to the State Agency (SA) documented in part . Admitting a resident with a fresh laryngectomy that the facility did not have the competence to care for, resulting in the facility having to rush the resident into a transfer the next morning.Review of the medical record revealed R708 was admitted on [DATE] and transferred out of the facility on 4/10/25. A review of the preadmission transferring hospital documents provided to the facility before and upon R708's admission identified the following:An otolaryngology progress note dated 4/3/25, documented in part . s/p (status post) total laryngectomy (surgical removal of larynx), bilateral neck dissection, left oropharyngectomy (surgical procedure to remove cancerous/diseased tissue from the left side of the throat behind the mouth), left partial glossectomy (surgical procedure portion of left side of tongue is removed), tracheostomy (surgical procedure that creates an opening in the trachea), direct laryngoscopy (medical procedure to examine/visualize the larynx), and free flap reconstruction with right ALT free flap (anterolateral thigh flap reconstruction). Laryngectomy Patient - Patient is a neck breather. HME valve is on [NAME] tube. Spare Bivona at bedside at all times. Laryngectomy care. NPO (nothing by mouth).A transfer summary dated 4/8/25, documented in part . Diagnosis. Oropharyngeal cancer. Total laryngectomy, bilateral neck dissection, L (left) oropharyngectomy, L partial glossectomy, tracheostomy, direct laryngoscopy and R (right) ALT free flap reconstruction - all on 3/20/25. s/p hematoma L neck evac 3/30/25. NPO (nothing by mouth), Two Cal HN (enteral feeding) via DH (dobhoff) tube, 4 cans/day to gravity. [NAME] Tube HME (heat moisture exchanger) w (with)/loose ties, Rt (right) leg open to air, dobhoff (small-bore feeding tube inserted through the nose and used for long-term enteral feeding) - crush meds (medications), 4/8/25 Preventive allevyn on coccyx, no bp (blood pressure) rt arm + leg. Encourage pt (patient) to help w/meds + feed. Place neck breather sign on wall please. The transfer summary was signed by the transferring Physician. Review of an admission progress note dated 4/9/25 at 8:46 PM, documented . Resident arrived to facility. Alert and oriented times 4. Communicates with a writing device. Is aware of what is going on and instrumental in his care. Resident has severe anxiety and was not adjusting well at first but seems to feel a little better. Safety maintained, suctioning machine at bedside. Res (resident) does prefer to suction self. Safety maintained, bedside remote and call light within reach. This note was documented by Licensed Practical Nurse (LPN) H. A nursing note dated 4/10/25 at 8:23 PM, documented . Resident is scheduled to be transported to another facility, (facility name) by (emergency services transport name). Resident is aware of the transfer and fine. He is due to depart this facility between 9 and 9:30 pm.A nursing note dated 4/11/25 at 12:35 AM, documented Resident departed the facility, headed to (facility name and city). Stable condition.A review of the Physician orders revealed no identification of the Tracheostomy size, cuff size or tracheostomy care. A review of the care plans revealed the following: A care plan titled . is at risk for respiratory distress, decannulation, infection r/t (related to) has Tracheostomy created 4/10/25 (the day after admission) (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented the following intervention Provide tracheostomy care/dressing change per order/facility protocol This intervention was not resident specific nor did it provide guidance for the facility staff to follow. A review of a facility policy titled Laryngectomy stoma and tube care revised 11/18/24, documented in part . Remove and discard the laryngectomy tube dressing. Remove the laryngectomy ties. Gently remove the laryngectomy tube, Clean and rinse the laryngectomy tube following the device manufacturer's instructions. Assess the stoma. Clean the stoma to remove secretions and crusting. gently pat dry with gauze pad. Special Considerations. Change the heat and moisture exchanger at least every 24 hours and more frequently if the patient reports increased breathing resistance. Clean the stoma edges and surrounding skin at least twice per day. Documentation associated with laryngectomy stoma and tube care includes. date and time of the procedure, respiratory assessment findings, condition of the stoma and surrounding skin, type of procedure performed, tolerance of the procedure, complications.There was no documentation in the medical record of the Laryngectomy care to have been completed. On 9/23/25 at 3:46 PM, the Director of Nursing (DON) was interviewed and asked why R708 was transferred to another facility one day after admission and the DON replied in part . because we didn't have the training completed for the tracheostomy. The DON stated they were not notified until the next morning of the resident's admission and they had the admission department work on getting the resident transferred out. The DON was asked how (R708) was approved to be admitted to the facility if they were not equipped to care for them and the DON stated that would be a question for the Admissions department. At 9/23/25 at 3:59 PM, the Director of Marketing (DM) J was interviewed and asked about the facility's admission protocol. DM J explained the facility has a green, yellow and red light system. The admission classified as green is cleared for admissions. The admission classified as yellow or red had to go to the DON for review. When asked what color R708 classified as, DM J stated they were classified as a yellow which required the review of the DON. DM J stated they had missed the documentation of the resident to have had a tracheostomy which would have classified them in as red because they . was aware of the building not being fully tracheostomy certified. DM J stated once they were informed of the resident status they worked on having the resident transferred to a facility with respiratory therapists and who were trained in tracheostomy care. On 9/24/25 at 12:51 PM, the Administrator was interviewed and asked if the DON was educated on the facility's admission protocol, after R708's tracheostomy status was missed as the second review on the admission referral. The Administrator stated the DON was not present in the facility that day and the second review of the referral packet was completed by the facility's Assistant Director of Nursing (ADON) K. On 9/24/25 at 1:36 PM, ADON K was interviewed and asked how R708 was admitted to the facility if the facility was not equipped to provide them with the care that they needed. ADON K explained they were new to the position as the ADON at the time of R708's admission and they were not aware that they were not supposed to take . care of trach's. The ADON K explained their background and stated they were experienced with trach residents and care. ADON K stated they have since been educated on the admission process. ADON K stated the facility is still currently not accepting tracheostomy residents. On 9/25/25 at 4:09 PM, LPN H (the nurse who completed the admission documentation) was interviewed and asked about the day R708 was admitted to the facility. LPN H explained they are the afternoon nurse supervisor for the whole facility. LPN H stated on that day they were helping another nurse out. LPN H stated the nurse originally assigned to R708 stated they were not comfortable caring for (R708) and they had no experience with tracheostomy's. LPN H was asked if the facility had the supplies to care for the resident and LPN H stated the resident came with supplies but was unsure of which supplies. LPN H stated they had no experience with tracheostomy either. LPN H explained they found a nurse on another floor with tracheostomy experience and switched their assignments and assigned them to R708. LPN H was asked why R708 was transferred out the next day and LPN H replied R708 could communicate by writing on a whiteboard. LPN H stated R708 immediately noted that they needed suctioning upon admission, and the initial assigned nurse stated (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they did not know how to do it. LPN H stated . It was a very scary situation because I wasn't comfortable. LPN H stated that R708 noted on the communication board . that he wasn't comfortable here (at the facility) and he was leaving tomorrow. LPN H stated they notified the DON of the resident's admission and the DON asked them .who authorized it (the admission) because I didn't. LPN H stated the facility was able to find staff experienced with tracheostomy care to be assigned to the resident until the resident was transferred out. No further explanation or documentation was provided by the end of the survey.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2605657. Based on observation, interview and record reviews the facility failed to ensure bladder incontinence care was completed timely for one (R702) of three residents reviewed for a urinary tract infection. Findings include:On 9/24/25 at 9:59 AM, R702 was observed sitting up in bed. When asked, R702 explained how they have been in and out of the hospital due to infections. R702 explained how they are .always wet and sitting in wet diapers for hours. This is why I always get infections. R702 stated they had not seen or met their Certified Nursing Assistant (CNA) for the day and the last time their brief was changed was by the night shift CNA at 6 AM. R702 stated they were wet and had been laying in their wet brief for some time. At 10:24 AM, an interview was conducted with CNA A. When asked CNA A confirmed they were assigned to R702 for their shift. CNA A was asked what time they began their shift and CNA A replied at 7 AM. CNA A was asked how many residents they were assigned to for their shift and CNA A replied thirteen. CNA A was asked about not checking in with R702 this morning regarding the bowel/bladder checks. CNA A was asked if it was normal for them to have been on duty for three and a half hours without checking in with their assigned residents to introduce themselves and to check on all assigned residents and CNA A replied they were actually late today but would check in on R702 now. At 10:25 AM, CNA A was observed to have removed the brief of R702. R702's brief was soaked with urine. The observation of the bed pad appeared to be dry, however dried urine stains were observed on R702's bed sheets. CNA A stated they would remove the stained bedding and apply all new sheets. Review of a facility policy titled Routine Resident Care revised 3/12/25, documented in part . Residents receive the necessary assistance to maintain good grooming and personal/oral hygiene. Incontinence care is provided timely according to each resident's needs.A review of the medical record, revealed R702 was admitted to the facility on [DATE], with a readmission date of 9/12/25 with medical diagnoses that included: Acute Pyelonephritis (infection of the kidneys), acute kidney failure- stage 3, endometriosis of the uterus, extended spectrum beta lactamase (ESBL) resistance, retention of urine, and the need for assistance with personal care.Further review of the medical record revealed R702 was recently hospitalized on [DATE] with a diagnosis of sepsis secondary to urosepsis versus opiate overdose in the setting of AKI (acute kidney injury). R702 was also recently hospitalized on [DATE] with a diagnosis of pyelonephritis. A review CNA A time sheet revealed on 9/24/25, CNA A was noted as Tardy and clocked in at 8:00 AM. On 9/24/25 at 12:58 PM, the Director of Nursing (DON) was interviewed and asked about the CNA coverage for R702 from 7:00 AM to 8:00 AM on 9/24/25 and the expectation of bowel and bladder checks for incontinent residents. The DON replied they would need to check on the CNA coverage for R702 and acknowledged the expectation for bowel and bladder checks to be done every two hours and as needed for incontinent residents. On 9/25/25 at 2:09 PM, a follow up interview was conducted with the DON that identified a miscommunication regarding the CNA coverage for R702, however verbalized an aide was assigned to R702 until CNA A arrived on duty. The DON acknowledged the concern for R702 to not have been checked for bowel/bladder incontinence from 6:00 AM to 10:30 AM, when the CNA was approached by the surveyor. The DON stated they have a meeting scheduled with the aides next week to discuss further education and expectations moving forward. No further explanation or documentation was provided by the end of the survey.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2605657Based on observation, interview and record review, the facility failed to ensure medications were stored appropriately in one medication cart of one medication carts reviewed for medication storage and labeling. Findings include:On 9/25/25 a concern submitted to the State Agency was reviewed which alleged facility staff were not storing medications properly. On 9/25/25 at approximately 11:22 a.m., a medication cart that was located on the second floor next to room [ROOM NUMBER] was observed unlocked and unattended by any Nursing staff. The medication cart top drawer was observed to contain multiple unidentified pills stored in an uncovered and unlabeled plastic cup as well as a second uncovered plastic cup full of a white powdery substance. No resident name was attached to the pills or powder that identified what the pills/powder were or what resident they belonged to. On 9/25/25 at approximately 11:25 a.m., Nurse Manager B (NM B) was observed coming out of a resident's room and was queried regarding the unlocked medication cart. Nurse B indicated they had forgotten to lock it when they left. NM B was queried regarding the uncovered plastic cups containing powder and multiple pills inside their unlocked medication cart and they reported they were saving them for later because a resident was not able to take them when they had brought them in for administration. NM B was queried if that was the normal process for storage of medication after not being able to be administered and they indicated it was not. On 9/25/25 a facility document titled Medication Administration was reviewed and revealed the following: Resident medications are administered in an accurate, safe, timely, and sanitary manner .2. Make sure that the medication cart is locked at all times when it is not in use or not within your constant vision. Store the locked medication cart in the appropriate storage area between med passes .10. Follow the medication/pharmacy guidelines for storage A second facility document titled Medication Management was reviewed and revealed the following: Medications are stored, dispensed and destroyed in a manner to ensure safety and conformance with state and federal laws .1. Non-controlled medications prepared, but not administered, are disposed of according to state law/guidelines. Controlled medications prepared, but not administered must be witnessed and countersigned by a licensed nurse on the controlled drug inventory sheet .

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #'s 2605657 and 2623220. Based on observation, interview and record review, the facility failed to ensure a substantial evening meal was provided for one resident (R709) of three residents reviewed for meals/food. Findings include:On 9/25/25 a concern submitted to the State Agency was reviewed which alleged residents were not receiving meals. On 9/25/25 at approximately 9:47 a.m., R709 was observed in their room, laying in their bed. R709 was observed to have contracted hands, turned into their palms. R709 was queried if they had any concerns regarding their care and they reported they were not provided with a dinner meal the previous day (9/24) and that the only food they got after lunch was a yogurt and chocolate pudding that the night Nurse gave them due to the kitchen being closed. R709 reported the facility never provided them with a supper meal tray at dinner and they did not get the yogurt until around 8:30 or 9:00 PM. R709 reported that their night Nurse (Nurse C) was aware of the issue and had gone to the kitchen for a tray and the kitchen was closed. R709 indicated that they require assistance with eating due to their hands and were unable to eat anything themselves, had lost weight and were afraid to be weighed due to knowing how much weight they have lost. On 9/25/25 the medical record for R709 was reviewed and revealed the following: R709 was initially admitted to the facility on [DATE] and had diagnoses including Parkinson's disease and Moderate protein-calorie malnutrition. A review of R709's MDS (minimum data set) with an ARD (assessment reference date) of 9/9/25 revealed R709 needed assistance from facility staff with their activities of daily living and was dependent on staff for eating. R709's BIMS score (brief interview of mental status) was 14 indicating intact cognition. A review of R709's careplans revealed the following: Focus-[R709] is at risk for alteration in nutrition and hydration status r/t (related to) Dx (diagnosis). chronic low back pain, Anxiety, Depression, Breast CA (cancer), Renal CA, Parkinson's disease. Suboptimal oral intake at times. Increased nutr (nutritional) needs to maintain wt (weight) and skin integrity Interventions-Provide diet as ordered: Regular diet, Mech Soft texture, thin consistency. Date Initiated: 09/05/2024 .On 9/25/25 at approximately 11:53 a.m., Nurse C was queried regarding R709 not getting assisted with the supper meal on 9/24. They indicated that they came on the shift at 7:00 PM and were not able to get R709 a meal, because they did not get to them until 8:30-9:00 PM, to check on them. Nurse C reported that when they found out R709 was not provided a supper meal tray, they went to the kitchen to try to get them one but at that time, the kitchen was closed and all they could get them was some yogurt and a chocolate pudding. Nurse C indicated that R709 is on a pureed diet and cannot eat regular food so they could only give them a yogurt and pudding. A further review of R709's medical record revealed the following Physicians order dated 6/9/25 for their therapeutic diet: Regular diet Level 3 Advanced (Mechanical Soft) texture, Thin consistencyOn 9/25/25 at approximately 3:35 p.m., Kitchen Manager D (KM D) was queried regarding R709's concern about not being provided a supper tray on 9/24. They reported that R709 had a recent room change, and the Nursing staff never sent the room change notification slip to the kitchen to notify kitchen staff that R709's room had been changed. KM D reported the kitchen still had not yet received a room change notification slip as of the morning of 9/25, but that the Dietician ended up updating the meal ticket in the morning. KM D indicated that R709's supper tray probably had gone to their old room, and nobody had brought it to their new room and that if Nursing staff do not inform the kitchen of the room change, then the meals will just go on the carts assigned to their old rooms. KM D reported that this issue has happened before, and Nursing staff forget to provide the room change notification slip to the kitchen.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 2605657. Based on observation, interview and record review, the facility failed to ensure infection control procedures were followed for one resident (R709) of three residents reviewed for infection control. Findings include:On 9/25/25 a concern submitted to the State Agency was reviewed which alleged the facility was not following infection control policies/procedures. On 9/25/25 at approximately 9:47 a.m., R709 was observed in their room, laying in their bed. R709 was observed to have contracted hands, turned into their palms. R709 was queried if they had any concerns regarding their care and they reported they were concerned about the facility having a COVID-19 outbreak. R709 was queried if staff had been observed wearing masks and gowns in their room and they reported that some do and some do not. On 9/25/25 at approximately 11:13 a.m., and 12:05 p.m., R709's door was observed to not contain any signage indicating staff were to use enhanced barrier precautions (EBP) when providing care to them. No bins containing personal protective equipment (PPE) were located next to their room to help direct care staff identify that EBP was to be provided to R709. On 9/25/25 at approximately 12:10 p.m., CNA F (Certified Nursing Assistant F) and CNA E were observed going into R709's room with a mechanical lift. Both CNA F and CNA E were observed to enter the room without donning any protective gowns or sanitizing their hands with alcohol-based hand rub (ABHR). On 9/25/25 at approximately 12:27 p.m., CNA F and CNA E were observed coming out of R709's room without doffing any PPE. CNA F was queried what care they provided to R709, and they indicated they were transferring them and repositioning them and helping with their contracted hands/arms. CNA F was queried if they had donned any protective gowns when providing the direct care and they indicated they did not because R709 did not have any signs or bins by their door indicating staff were to use PPE when providing care. On 9/25/25 at approximately 12:59 p.m., CNA G was observed pushing an open cart with two meal trays on it down the hallway. Both of the meal trays were observed to have uncovered/unprotected deserts on them. CNA G was then observed taking the meal trays into two different rooms from the hallway. CNA G was queried why the deserts did not have a protective covering on them and they indicated that they should have but the kitchen staff must have forgotten to put them on. On 9/25/25 at approximately 1:06 p.m., CNA F was observed entering R709's room without applying any ABHR before entering. On 9/25/25 at approximately 1:26 p.m., R709's room was still observed to not contain any signage indicating staff were utilize enhanced barrier precautions. On 9/25/25 at approximately 1:34 p.m., Nurse Manger B (NM B) was queried if R709 required any precautions and they indicated they would have to check their orders. At that time, NM B was observed reviewing R709's medical record and reported that R709 should be provided enhanced barrier precautions. NM B indicated they would have to put a sign up and a PPE bin to ensure staff were following the precautions when providing care. On 9/25/25 the medical record for R709 was reviewed and revealed the following: R709 was initially admitted to the facility on [DATE] and had diagnoses including Parkinson's disease and Moderate protein-calorie malnutrition. A review of R709's MDS (minimum data set) with an ARD (assessment reference date) of 9/9/25 revealed R709 needed assistance from facility staff with their activities of daily living and was dependent on staff for eating. R709's BIMS score (brief interview of mental status) was 14 indicating intact cognition. An active Physician's order dated 8/20/25 revealed the following: Enhanced Barrier Precautions R/T (related to) HX (history) ESBL (Extended-spectrum beta-lactamases-infection) and WoundOn 9/25/25 a facility document titled Multi Route Transmission Based Precautions was reviewed and revealed the following: Policy: Transmission-based precautions are the second tier of basic infection control are to be used in addition to standard precautions for residents who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission .A review of the Centers for Disease Control website revealed the following regarding enhanced barrier precautions: Enhanced Barrier Precautions (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) .